No. 90-97

In The

Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF OF HOSPITAL ASSOCIATION OF PENNSYLVANIA, ST. MARGARET MEMORIAL HOSPITAL AND McKEESPORT HOSPITAL AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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PARTIES TO THE PROCEEDINGS

In addition to the parties named in the caption, the following entities and individuals were appellants in the court of appeals and are respondents in this Court:

James M. Stephens
Mary M. Cracraft
Dennis M. Devaney
Clifford R. Oviatt, Jr.*
John C. Truesdale
American Nurses Association
American Federation of Labor and Congress of Industrial Organization
Building and Construction Trades Department, AFL-CIO

*Substituted as a respondent pursuant to Rule 35.3 of the Rules of this Court.

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STATEMENT OF INTEREST

Hospital Association of Pennsylvania ("HAP"), St. Margaret Memorial Hospital ("St. Margaret") and McKeesport Hospital ("McKeesport") submit this joint brief as *amici curiae* in support of Petitioner, American Hospital Association ("AHA"). Both McKeesport and St. Margaret are "acute care hospitals" as defined in Respondent National Labor Relations Board's (the "Board" or "NLRB") Final Rule for Collective-Bargaining Units in the Health Care Industry (the "Final Rule"), 54 Fed. Reg. 16347-16348 (1989); 29 C.F.R. § 103.30. HAP is a state-wide association of health care institutions.

HAP views itself as the Pennsylvania health care industry's principal forum for developing public policy initiatives and for the exchange of ideas on the effective delivery of quality health care services. To that end, HAP represents its members on a wide variety of matters including legislation and litigation affecting the member hospitals. HAP's entire membership, both unionized and unorganized, is vitally concerned that reasoned legal principles exist for the purpose of making unit determinations in the vast array of differing institutions which make up the hospital community. There is no room for arbitrary, capricious issue resolution in such matters.

McKeesport and St. Margaret, along with all other acute care hospitals and members of HAP, will be directly affected by the Board's Final Rule which was upheld by the United States Court of Appeals for the Seventh Circuit. The AHA has petitioned the Court for review of the Seventh Circuit's decision.

St. Margaret is a 287 bed hospital located in Pittsburgh, Pennsylvania which employs approximately 1,300 regular full and part-time employees. Although none of the employees at St. Margaret are represented by a labor organization, a petition was filed with Region Six of the NLRB on April 27, 1990 by International Union of Operating Engineers, Local 95-95A, AFL-CIO (the "Operating Engineers") by which it seeks to represent a unit limited to 17 skilled maintenance

employees,[1] one of the eight specific bargaining units irrebuttably presumed to be "appropriate" by the Board in its Final Rule. 29 C.F.R. § 103.30(a)(5). That petition is being held in abeyance by the NLRB pending the Court's decision in this case.[2] Thus, St. Margaret and other hospitals similarly situated will be directly affected by the Board's Final Rule, if upheld.[3]

McKeesport Hospital, located in McKeesport, Pennsylvania, employs 1,584 regular full and part-time employees to care for the needs of patients in its 420 licensed beds. A significant number of the employees at McKeesport are represented for collective bargaining. Both registered nurses and licensed practical nurses are represented in a single unit by the General Staff Nurses Association of McKeesport Hospital, Service Employees International Union, Local 585, AFL-CIO ("Local 585"); skilled maintenance employees are represented by Operating Engineers, Local 95-95A; and the Hospital's service employees are represented by Service Personnel & Employees of the Dairy Industry, Teamsters Local Union No. 205 a/w International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, AFL-CIO (the "Teamsters"). McKeesport's physicians, other professional employees, technical employees, clerical employees, other nonprofessional employees and security guards, are not presently represented by any union.

The recent history of McKeesport is a case study of the disruptive effects of the work stoppages, whipsawing and leapfrogging which Congress feared would result from the

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[1] NLRB Case No. 6-RC-10447.

[2] See N.L.R.B. General Counsel Memorandum, 89-7 (May 30, 1989).

[3] The law firm of Cohen & Grigsby represents approximately 35 acute care hospitals in Pennsylvania, West Virginia and Ohio. Significantly, the petition at St. Margaret is only one of four petitions filed by the Operating Engineers now pending at the NLRB's Region Six office in Pittsburgh. The most recent petition, involving St. Clair Memorial Hospital, was filed on September 12, 1990 at NLRB Case 6-RC-10509. The other petitions in Region Six seeking a skilled maintenance unit under the Final Rule involve Shadyside Hospital (NLRB Case 6-RC-10446) and Central Medical Center (NLRB Case 6-RC-10445).

proliferation of health care bargaining units. While the NLRB in its rulemaking has said that it found little evidence that multiple units have resulted in strikes, jurisdictional disputes and whipsawing, McKeesport's experience with only three units contradicts this finding and illustrates the disastrous impact that proliferation will have on the future of labor relations in acute care hospitals if the eight unit Final Rule is upheld.

Because of the serious adverse economic and operational impact that the Board's Final rule has on St. Margaret, McKeesport and other acute care hospitals which are members of HAP, we submit this brief in support of the AHA's Petition.[4]

SUMMARY OF ARGUMENT

The cases of St. Margaret and McKeesport convincingly illustrate the adverse effects that the Board's Final Rule will have on the already troubled health care industry. The concerns which caused the authors of the 1974 Health Care Amendments to the National Labor Relations Act ("NLRA"), Act of July 26, 1974, Pub.L. No. 93-360, 88 Stat. 395, to recognize the need to afford hospitals special protection to minimize the adverse effects of work stoppages and other disruptions to safe patient care remain present and, in some ways have now taken on new proportions. The cost of health care has continued to skyrocket far beyond the expectations of the legislators in 1974 when they commanded the NLRB to take this into account, and threatens to make proper health care unachievable for many Americans. It has never been more important than the present to protect the public interest by affording hospitals the safeguards which Congress envisioned to be necessary when it admonished the NLRB to avoid undue proliferation of bargaining units in hospitals.

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[4] The law firm of Duane, Morris & Hecksher, General Counsel for HAP, concurs with, and joins in the position of amici curiae.

St. Margaret, McKeesport and HAP agree with the AHA that the Final Rule conflicts with the Congressional admonition accompanying the 1974 amendments to "prevent proliferation of bargaining units in the health care industry;" that it is contrary to Section 9(b) of the Act; and that it is arbitrary and capricious and not based on substantial evidence.

The NLRB Final Rule, approved by the Seventh Circuit, is at odds with the legal precedent of the Courts of Appeals in several circuits, including the Second and Third Circuits and creates undue proliferation of bargaining units, particularly insofar as the decision upholds the validity of a separate skilled maintenance employee unit as petitioned for at St. Margaret.

McKeesport's experience colorfully illustrates that the Board's Final Rule is erroneous insofar as it has determined that the work stoppages, whipsawing and leapfrogging feared by Congress when it extended the Act to cover non-profit hospitals, has not occurred in hospitals with multiple bargaining units.

ARGUMENT

A. The Legislative History And The Congressional Admonition Clearly Define The NLRB's Duty To Avoid The Undue Proliferation Of Bargaining Units In The Health Care Industry.

In 1974 Congress amended the National Labor Relations Act to cover all private health care institutions, including non-profit hospitals. Due to the fact that hospitals provide care for the ill, the aged and the infirmed, Congress sought to provide certain restrictions on unit proliferation in the health care industry.

The legislative history of the 1974 Amendments makes clear that Congress considered proliferation of bargaining units a danger to patient care and feared that it would lead to increased co... for medical care. To address these concerns, both the House and Senate Committee Reports contain language agreed upon by both supporters and opponents of the amendments. This legislative history reads as follows:

> "Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend towards broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973)." (Footnote omitted)

S.Rep.No. 93-766, 93d Cong., 2d Sess. 5 (1974), *reprinted in* 1974 U.S.Code Cong. & Ad. News, pp. 3946, 3950, H.R.Rep.No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

Senator Taft, one of the primary sponsors of the legislation, explained that the "agreed upon . . . report language . . . [was] *endorsed by labor and management groups*, including the Service Employees International Union of the AFL-CIO, the Laborers' International Union of North America of the AFL-CIO, many State Hospital Associations . . . the Department of Labor and the Office of Management and Budget . . . . " 120 Cong.Rec. 12,944 (1974) (emphasis added).

Senator Taft further explained the rationale for Congress' admonition in the Committee Reports:

> "I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of *great caution* being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented . . . .
>
> In analyzing the issue of bargaining units, *the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage 'leapfrogging' and 'whipsawing.' The cost of medical care in this country has already skyrocketed*, and the cost must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

> The committee in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases." 120 Cong.Rec. 12,944-45 (1974) (emphasis added).

Shortly after the Act was amended, the NLRB considered the appropriateness of bargaining units in a series of cases then pending before the Board.[5] Having determined that these cases present issues of importance in administration of the Act, the Board held oral argument, and amici curiae briefs were received. From that point forward, the National Labor Relations Board has acknowledged that the Congressional admonition provides special guidance with respect to determining bargaining units in the health care industry. The "*principle thrust of the legislative history of the health care amendments . . . admonishes the Board to avoid undue proliferation of bargaining units.*" *Mercy Hospitals of Sacramento, Inc.*, 217 N.L.R.B. 765, 766 (1975) (emphasis added).

The courts of appeals in heretofore reviewing NLRB cases have uniformly, if not unanimously, recognized a responsibility on the part of the Board by virtue of the admonition to avoid the undue proliferation of bargaining units in the health care industry.[6] Although the approaches

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[5] *Mercy Hospitals of Sacramento, Inc.*, 217 N.L.R.B. 765 (1975); *Barnert Memorial Hospital Center*, 217 N.L.R.B. 775 (1975); *St. Catherine's Hospital*, 217 N.L.R.B. 787 (1975); *Newington Children's Hospital*, 217 N.L.R.B. 793 (1975); *Sisters of St. Joseph of Peace*, 217 N.L.R.B. 797 (1975); *Duke University*, 217 N.L.R.B. 799 (1975); *Mount Airy Psychiatric Center*, 217 N.L.R.B. 802 (1975); and *Shriners Hospitals*, 217 N.L.R.B. 806 (1975).

[6] See, *St. Anthony Hosp. Systems, Inc. v. NLRB*, 884 F.2d 518, 521 (10th Cir. 1989) (" . . . when a bargaining unit satisfies the 'disparity of interests' test, it necessarily complies with the Congressional directive against unnecessary fragmentation of bargaining units"); *St. John's General Hospital v. NLRB*, 825 F.2d 740, 747 (3d Cir. 1987) ("The Board must consider the issue of undue proliferation in determining the scope of a bargaining unit"); *Southwest Community Health Services v. NLRB*, 726 F.2d 611, 613 (10th Cir. 1984) ("Congress has admonished the Board to prevent a proliferation of bargaining units in the health care

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recognized by the various courts of appeals vary somewhat it can be gleaned from the decisions that, at the very least, the admonition requires the Board to apply a standard in determining units in the health care industry which is something more than the traditional community of interest standard applied in other industries. When the "smoke and mirrors" are removed from the Board's Final Rule, it is evident that the Board has not substantially departed from its traditional approach and, thus, has not complied with the Congressional mandate to avoid undue proliferation of bargaining units in the health care industry.

In *American Hospital Association v. NLRB*, 899 F.2d 651, 659 (7th Cir. 1990), the decision below, the Seventh Circuit, too, has merely paid "lip service" to Congress' admonition against unit proliferation by concluding that the Board's Final Rule did not constitute undue proliferation in conflict with Congress' intentions.

(Continued from previous page)

industry"); *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1538-39 (11th Cir. 1984), *reh'g den.*, 726 F.2d 755 (11th Cir. 1984) ("A general rule derived from the above cited cases is that the Board must consider Congress's nonproliferation directive and discuss how the Board's action in a particular case comports with that directive"); *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1470 (7th Cir. 1983) (" . . . the circuits including ours have treated [the committee reports] as authoritative); *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632-33 (2d Cir. 1983) (" . . . this legislative commitment to nonproliferation, explicit in the legislative history binds the NLRB . . . "); *NLRB v. HMO International/Cal. Medical Group Health Plans, Inc.*, 678 F.2d 806, 808-09 (9th Cir. 1982) ("Because this legislative commitment to non-proliferation is explicit in the legislative history leading to the repeal of the prior exemption, it is binding on the NLRB and must be implemented by it"); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981) (" . . . the Board must expressly consider the congressional admonition in making unit determinations"); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 215-16 (7th Cir. 1978) ("Congress has made it clear that the Board must view evidence of traditional factors in the context of the stated Congressional policy of preventing proliferation of bargaining units in the health care field"). Contra, *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987).

Legislative history explaining legislative enactments has considerable significance in guiding a court in the interpretation of a statute. While a committee report is not a statute, it can and does illuminate statutory language. This Court has looked to legislative history on numerous occasions to assist it in interpreting Congressional intent in labor legislation, and particularly the NLRA.[7]

Indeed, the decisions of the numerous courts of appeals which have interpreted the statute and the legislative history *require* the NLRB to do more than apply traditional standards to avoid undue proliferation of health care units, and are legal precedent which the NLRB and Seventh Circuit cannot ignore. It is the courts of appeals, not the NLRB, which have been given superior authority by the legislature to interpret the statute. *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191, 194 (4th Cir. 1982) ("a reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation"); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 970 (3d Cir. 1979) (" . . . the Board is not a court nor is it equal to this court in matters of statutory interpretation . . . . For the Board to predicate an order on its disagreement with this court's interpretation of a statute is for it to operate outside the law").

The NLRB Final Rule ignores the effect the many courts of appeals have given to the admonition by establishing eight bargaining units to be appropriate based upon nothing more than traditional standards. The NLRB is not free to disregard the superior role of the courts of appeals with regard to the effect to be given legislation, and, by the Final Rule, to depart from now settled law. Therefore, this Court should look to the legislative history of the amendments and protect the public interest by giving effect to the true intent of Congress, to avoid the undue proliferation of bargaining units in the health care industry.

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[7] See, *Edward J. De Bartolo Corp. v. NLRB*, 463 U.S. 147, 154-57 (1983); *National Woodwork Manufacturers Association v. NLRB*, 386 U.S. 612, 640 (1967); *United States v. International Union United Automobile, Aircraft & Agricultural Implement Workers of America*, 352 U.S. 567, 585 (1957).

B. The Board's Final Rule Is Arbitrary And Capricious And Not Supported By Substantial Evidence Insofar As It Ignores The Critical Differences Among Hospitals.

It is truly paradoxical that in the one industry in which Congress' concern for the public interest caused it to specifically instruct the Board to avoid the undue proliferation of bargaining units, it is now the only industry in which the Board has chosen to determine units by blanket rules, which, by their very nature, cause proliferation of bargaining units. Even more curious, perhaps, is that by doing so the NLRB has contradicted its own prior acknowledgments and the numerous and consistent admonishments of the courts of the need for flexibility in determining units in the health care industry.

The diversity of the health care institutions and the need for flexibility in making unit determinations in health care was recognized by the Board from the outset. In *Otis Hospital, Inc.*, 219 N.L.R.B. 164 (1975), a case decided shortly after the amendments became effective, the Board, believing its conclusion to be consistent with the legislative history of the amendments, held that employers and unions should be granted the "broadest possible latitude" in agreeing upon unit compositions, and expressly acknowledged that "*not all health care institutions may be exactly alike.*" It explained:

> "That is, we feel, the first lesson learned from the recent debates. *Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself.* When parties contest the emphasis to be given to such characteristics, we are, of necessity, the arbiter." *Id.* at 165 (emphasis added).

If there has been any change at all since the NLRB's 1975 pronouncements, it is that hospitals have, of necessity, become more diverse due to the increasing complexity of health care and the influences of the market place.

Decisions of the courts of appeals also recognize the diversity of the health care industry and the requirement that the Board consider the particular facts in exercising its discretion in each case when determining health care bargaining units. An early example is *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351 (3d Cir. 1976), where the Board failed to exercise its own discretion in determining an appropriate unit by merely granting comity to a state court certification. In *Memorial Hospital*, the Third Circuit described the Board's responsibility as follows:

> "In reviewing the Board decisions under § 9(b), our function is circumscribed by the nature of the Board's responsibility with respect to the determination of appropriate units. *It is clear that '[t]he issue as to what is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision.* It involves of necessity a *large measure of informed discretion' . . .* " *Id.* at 357 (citation omitted) (emphasis added).

With this precept in mind, the court concluded that the Act *and* the legislative history of the amendments prohibit the Board from abdicating its duty to decide the appropriate unit in "each and every case." *Id.* at 360. *Accord, Long Island College Hospital v. NLRB*, 566 F.2d 833 (2d Cir. 1977).

The courts also heretofore have expressed disfavor of the Board's abdication of its duty to decide appropriate units in health care institutions by reliance on irrebuttable presumptions. In *NLRB v. St. Francis of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979), the Ninth Circuit explained:

> "By setting up a policy which is automatically applied and irrebuttable without any examination of the particular situation involved, the Board fails to give 'due consideration' to the congressional directive in that case."

Following this decision of the Ninth Circuit, the Board embraced the court's reasoning in *Newton-Wellesley Hospital*,

250 N.L.R.B. 409 (1980), and expressly disavowed any establishment of irrebuttable presumptions in determining health care units. The Board added:

> "*Such a **per se** approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide 'in each case' whether the requested unit is appropriate.* Moreover, as the court pointed out, the legislative history of the 1974 health care amendments to the Act requires the Board to give due consideration to avoiding an unwarranted fragmentation of bargaining units in this industry. A ***per se*** rule could result in the Board's giving insufficient attention to this admonition of the Congress, and could permit the splitting of professional or other employees into separate units regardless of whether the particular circumstances warranted such a division." *Id.* at 411 (emphasis added).

While the Board more recently adopted the "disparity of interest" approach in *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) ("St. Francis II"), which essentially presumes the appropriateness of professional and non-professional units, the Board again emphasized:

> "We will reach our unit determinations on a case-by-case basis, focusing on the differences shown by the petitioned-for unit from other employees and the similarities among the proposed unit members. *The diverse nature of today's health care industry – including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc. – precludes any generalization as to the appropriateness of any particular bargaining unit.*" *Id.* at 953 n.39 (emphasis added).

Thus, it has been uniformly recognized by the Board and courts, and is clear from the legislative history of the amendments, that the Board has an affirmative duty under Section 9(b) of the Act and the Congressional admonition to consider the critical differences of particular health care institutions before determining appropriate bargaining units and to determine in each case that the units approved do not constitute undue proliferation.

Yet there have been no intervening events or vast changes in the industry to cause the Board to contradict, in the Final Rule, its prior acknowledgments. The health care industry has been, and remains, a very diverse industry in many respects.

HAP represents approximately 252 health care institutions in Pennsylvania which are potentially affected by the rule, of various sizes, in metropolitan, suburban and rural settings. These institutions have significant differences in missions, patient populations, work force structures and reimbursement structures. Virtually all have work forces that are functionally integrated to varying degrees and many utilize concepts such as the team approach to providing health care, multi-disciplinary teams, overlapping work functions, and various forms of departmental organization, staffing and supervision, etc. Nor is the industry static. Several external forces are presently at work influencing the industry to make changes. Among these forces are the rising costs of medical care, shortages of registered nurses and other specialists, changes in levels of reimbursement and, above all, ever changing technology which requires further specialization and diversity in the work force. All will impact different hospitals in different ways and to different degrees. Surely changes in the scope and composition of health care industry work forces are likely to occur, resulting in further diversity, as hospitals explore new and innovative ways to solve these problems.

The Board has consistently relied upon factors such as integration of the work force, employee contact, shared job duties, common supervision and other terms and conditions of employment in evaluating whether groups of employees should be in the same or different bargaining units. While some trends or patterns have developed and are recognized by the NLRB with respect to determining the scope and composition of bargaining units, the NLRB has heretofore refused to apply inflexible rules, in favor of deciding each case based on its own particular facts and circumstances.

Thus, the diverse nature of health care institutions gives rise to significant differences in terms and conditions of employment among hospitals, which the NLRB has consistently acknowledged during its 13 years of deciding cases

under the 1974 amendments. Before rulemaking, it has, as set forth above, consistently expressed its opinion that the admonition precludes it from utilizing any approach which would fail to consider the particular facts of each case. The diversity in health care institutions and their work forces require that unit determinations be made solely on the basis of first hand, institution-specific evidence.

Suddenly, in direct contradiction of its earlier acknowledgments, the NLRB announced that it will determine health care bargaining units by rulemaking. The Board, by its Final Rule, will no longer consider the particular facts in deciding the appropriate unit in each case, abdicating its duty under Section 9(b) of the Act. This drastic change in approach, ostensibly resulting from the NLRB's inability to expeditiously process and determine units on a case-by-case basis or to gain the uniform approval of the courts of appeals does not relieve it of its statutory duty, affirmed by the courts, to avoid the proliferation of health care units merely for the sake of administrative ease. The Congressional admonition to avoid the proliferation of units is of paramount importance to the NLRB's justifications for engaging in rulemaking. A blanket rule which fails to consider these critical differences and the potential for changes in the industry will result in unit determinations in health care which are simply incorrect, even under traditional standards. The Board's failure to consider the critical differences among the various hospitals inescapably leads to the proliferation of units in clear contradiction of the congressional mandate.

C. The Board's Rule Determining That Eight Separate Bargaining Units Are Appropriate Is Inconsistent With The Congressional Admonition To Prevent Undue Proliferation Of Bargaining Units In The Health Care Industry.

The NLRB's Final Rule, determining that eight separate bargaining units are appropriate in all hospitals covered by the rule constitutes undue proliferation of units in violation of

the Congressional admonition. While there may be circumstances where each of the eight units is appropriate, an inflexible rule commanding that all eight units are appropriate in all hospitals covered by the Rule cannot be reconciled with Congress' mandate. The fact that the NLRB and courts have, during years of experience deciding such matters by adjudication, often refused to approve many of the units determined to be appropriate by the Final Rule as being contrary to the admonition, is compelling evidence that the Final Rule causes undue proliferation of health care bargaining units.

Perhaps the best illustration of these points is the manner in which the NLRB and courts have dealt with the skilled maintenance unit since the 1974 amendments. As set forth below, it is evident that in over 13 years of deciding the appropriateness of health care bargaining units, particularly with respect to maintenance employees, the NLRB's determinations have lacked consistency. In fact, before the Final Rule was put into effect, it appears the Board has, more often that not, found separate units of skilled maintenance employees *not* to be appropriate. And, although the Board approved separate maintenance units in many cases, *no* court of appeals has approved such a unit. Thus, the Board's determination by rulemaking that the eight bargaining units are irrebutably presumed to be appropriate in every case, when the Board has not consistently reached such determinations through adjudication or gained the courts' approval of such units, is arbitrary, capricious and not supported by the evidence and results in the undue proliferation of bargaining units contrary to the express intent of the 1974 amendments.

Shortly after the amendments were passed, the Board considered several cases then pending before it concerning the appropriateness of bargaining units. One of these decisions, *Shriners Hospitals*, 217 N.L.R.B. 806 (1975), was the very first case under the amendments in which the Board dealt specifically with the issue of whether a separate unit of stationary engineers is appropriate in the health care industry.[8] A majority of the Board decided that such a separate unit

[8] Typically, stationary engineers make up a large portion of skilled maintenance units.

in the health care industry is *not* appropriate in light of the Congressional admonition to avoid undue proliferation of bargaining units:

> " . . . Mindful of the congressional mandate and in the exercise of our discretion, we find that, in the health care industry, *the only appropriate unit for collective bargaining which encompasses stationary engineers is a broad unit consisting of all service and maintenance employees* of the Employer, excluding professionals and business office clericals." *Id.* at 808 (emphasis added).

Significantly, the *Shriners* decision was issued only after a very careful and deliberate analysis of the facts in that particular case, and with the benefit of the records, testimony and arguments presented in the several other cases concurrently considered and decided.

In many similar cases subsequent to *Shriners*, the Board also found separate skilled maintenance units *not* appropriate.[9] Yet, in other cases separate maintenance units were approved by the Board.[10] But in those cases which were appealed to the courts of appeals, the courts, without exception, refused to accept the NLRB's certification of a separate unit of maintenance employees.

[9] *Metropolitan Hospital*, 223 N.L.R.B. 282 (1976); *Jewish Hospital Association of Cincinnati*, 223 N.L.R.B. 614 (1976); *Riverside Methodist Hospital*, 223 N.L.R.B. 1084 (1976); *Baptist Memorial Hospital*, 224 N.L.R.B. 199 (1976); *St. Joseph's Hospital*, 224 N.L.R.B. 270 (1976); *The Paul Kimball Hosp., Inc.*, 224 N.L.R.B. 458 (1976); *Greater Bakersfield Memorial Hospital*, 226 N.L.R.B. 971 (1976); *Sutter Community Hospitals of Sacramento, Inc.*, 227 N.L.R.B. 181 (1976); *Anaheim Memorial Hospital Association*, 227 N.L.R.B. 161 (1976); *Northeastern Hospital*, 230 N.L.R.B. 1042 (1977); *Peter Bent Brigham Hospital*, 231 N.L.R.B. 929 (1977).

[10] *McLean Hosp.*, 234 N.L.R.B. 424 (1978); *Hebrew Rehabilitation Center*, 230 N.L.R.B. 255 (1977); *Trinity Memorial Hospital*, 230 N.L.R.B. 855 (1977); *Sinai Hospital of Detroit, Inc.*, 226 N.L.R.B. 425 (1976); *Eskaton American River Healthcare Center*, 225 N.L.R.B. 755 (1976); *West Suburban Hospital*, 224 N.L.R.B. 1349 (1976); *St. Francis Hospital-Medical Center*, 223 N.L.R.B. 1451 (1976).

In *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977), the Third Circuit, certifying the Board's decisions in *Shriners Hospitals* and *Jewish Hospital Association* to be "correct expressions of the law," set aside the Board's order, finding the unit *not* to be appropriate in light of the congressional admonition. The court criticized the Board for mechanically relying on traditional community of interest criteria to find the maintenance unit appropriate, instructing that:

> "The legislative history of the health care amendments, however, makes it quite clear that Congress directed the Board to apply a standard in this field which is not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital." *Id.* at 592.

The Seventh Circuit in *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978), also chastised the Board for merely paying "lip service" to the admonition and further criticized the Board for relying on traditional factors in finding a separate maintenance unit appropriate. *Id.* at 215.

Subsequently, the Board, in *Allegheny General Hospital*, expressing disagreement with the courts, again found a separate maintenance unit appropriate.[11] The NLRB took exception to the Third Circuit's decision in *St. Vincent's Hospital* in two respects. First, explaining that it had carefully reconsidered the legislative history of the 1974 amendments, the NLRB concluded, that, "with all due respect to the court, Congress did not intend to prohibit such units." *Id.* at 872. Secondly, the NLRB disagreed with the court's holding that the 1974 amendments also precluded the Board from relying on its traditional community of interest criteria in making health care unit determinations. *Id.* at 878.

In *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979), Judge Aldisert, writing the Opinion of the Court,

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[11] 239 N.L.R.B. 872 (1978).

chastised the Board for ignoring the court's earlier decisions in *Memorial Hospital of Roxborough* and *St. Vincent's Hospital* and, addressing the concept of precedent or *stare decisis*, went on to explain:

> " . . . the Board is not a court nor is it equal to this court in matters of statutory interpretation. Thus, a disagreement by the NLRB with a decision of this court is simply an academic exercise that possesses no authoritative effect. It is in the Court of appeals and not in an administrative agency that Congress has vested the power and authority to enforce orders of the NLRB 29 U.S.C. §160(e). . . . *Thus, it is in this court by virtue of its responsibility as the statutory court of review of NLRB orders that Congress has vested a superior power for the interpretation of the congressional mandate. Id.* at 970 (emphasis added).

Finally, the court held that the Board's use, in the health care industry, of the *American Cyanamid*[12] test, which is merely the traditional community of interest test applied to maintenance units in other industries, is unacceptable since it does not consider the effects of bargaining unit fragmentation or the special public interest in hospital unit determinations.

In St. Francis II,[13] the Board announced that it would henceforth apply the Ninth and Tenth Circuit Courts of Appeals' "disparity of interest" analysis in determining health care bargaining units. When this approach was not approved by the court of appeals, the Board announced that it intended to engage in rulemaking.[14]

Thirteen years after the amendments were passed, the Board published its First Notice of Rulemaking 52 Fed.Reg. 25,142 (1987) ("NPR I") which *did not* propose a separate skilled maintenance unit, nor did it propose a separate unit for

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[12] *American Cyanamid Company*, 131 N.L.R.B. 909 (1961).

[13] *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) ("St. Francis II").

[14] The D.C. Circuit refused to enforce the Board Order on the basis that the amendments do not mandate the use of a "disparity of interest" analysis and the court's use of such a test was deemed an erroneous view of the law. *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987).

business office clerical employees. The Board explained its decision not to find a separate unit of skilled maintenance employees appropriate as follows:

> "Similarly, although at times the Board has in the past approved separate units of skilled maintenance employees (including stationary engineers), in our proposed rule we have provisionally included such employees in service and maintenance units for several reasons. First, we have found that their skill levels at times do not greatly exceed those of other unit employees. Second, many skilled maintenance employees work throughout hospitals' facilities, and thus frequently come into contact with other unit employees. Third, inclusion of skilled maintenance employees in broader units will help to prevent unit proliferation. By contrast, if we were to approve separate skilled maintenance units, many of which would be quite small both in absolute size and relative to the remaining service and maintenance employees, we might well be faced with requests to grant other small units of specialized employees; were we to grant such requests, we would open the door to unit fragmentation and proliferation. Finally, as a practical matter, *when the Board has approved separate maintenance units, its decisions have fared poorly in the courts.*" 52 Fed.Reg. at 25,147 (footnotes omitted) (emphasis added).

In NPR II, 53 Fed.Reg. 33,900 (1988), the Board reversed the position it took in NPR I and announced that a skilled maintenance unit would constitute a separate appropriate unit. Curiously, the Board essentially considered the same factors as it had in numerous previous cases and NPR I, but reached an opposite result.[15]

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[15] In a futile effort to demonstrate that the Board's adjudication of bargaining unit cases has been uniform, the NLRB suggested in NPR II that the varying results for skilled maintenance units were largely a function of a single Board member, Member Jenkins, reaching different results in different cases. NPR II, 53

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The courts of appeals reviewing hospital unit cases have virtually all expressed that the Congressional admonition *requires* the Board to use a standard which is more than the traditional standards used in other industries to determine units. But the Board, choosing to ignore the courts of appeals, as illustrated by the manner in which maintenance units were determined, continued to apply traditional community of interest criteria, thereby failing to properly consider Congress' mandate to avoid undue proliferation.

Although the Board attributes its changes in position in its Final Rule to careful consideration of evidence amassed during rulemaking, it is clear from a review of the many cases in which the NLRB considered the maintenance employee issue, that the wages, hours and other terms and conditions of these employees, relative to other hospital employees, have not significantly changed during the 16 years since the amendments.

The record shows that the NLRB decided more than 30 cases dealing with separate maintenance units on a case-by-case basis prior to NPR I. Surely, in its typical, thorough Board fashion, it developed complete, first-hand records in these cases, including testimony of employees, supervisors and managers of those hospitals, all of whom testified under

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Fed.Reg. at 33,903. What the Board fails to mention in NPR II is that in each of those cases where skilled maintenance units were found *not* appropriate, at least two other Board members, most often Members Penello and Walthers, rejected the skilled maintenance unit. While it may be true that Chairmen Murphy and Fanning were remarkably uniform, it is at least equally significant that other Board members, including Chairman Van DeWater and Dotson and Members Dennis, Johanson and Babson, in different opinions, expressed the view that separate maintenance units are not appropriate. *The Community Hospital at Glen Cove*, 278 N.L.R.B. 80 (1986); *St Francis Hospital*, 265 N.L.R.B. 1025 (1982). Finally, it is also significant that Chairman Murphy and Member Fanning, in finding separate maintenance units appropriate, relied on the *American Cyanamid* test, which is nothing more than a mere application of community of interest criteria, and which, we submit, does not adequately consider the admonition to avoid the undue proliferation of bargaining units and has since been rejected by the courts. See *Greater Bakersfield Memorial Hospital*, 226 N.L.R.B. 971 (1976).

oath and were subject to cross examination, and obtained necessary documentation, records and exhibits, etc., before rendering its decisions. After reviewing its experience during 13 years of carefully deciding these issues through adjudication, based upon extensive institution-specific records, the Board determined that a separate maintenance unit is *not* appropriate. The Board's analysis and conclusion in NPR I were correct insofar as the Board concluded therein that a separate unit of skilled maintenance employees is *not* appropriate. The Board's Final Rule as to skilled maintenance units is based only on a record of generalities and upon the self-serving testimony of special interest groups without regard to the actual experiences of the many, very different institutions and patient care communities which will be affected.

The Board's Final Rule finding separate units of skilled maintenance employees appropriate also ignores uniform precedent in the courts of appeals which holds that such units constitute undue proliferation in contradiction of the Congressional admonition. Since 1974, as we noted above, three courts of appeals in seven separate cases denied enforcement of Board Orders finding separate maintenance units appropriate, while *no court of appeals has ever approved such a unit.*

The NLRB has overstepped its authority by implementing a rule which ignores clear legal precedent. The courts of appeals are the statutory courts of review of NLRB orders, and as such, are vested with a superior power to interpret the congressional mandate.[16] "Congress has not given to the NLRB the power or authority to disagree, respectfully or otherwise with decisions of this court." *Allegheny General Hospital v. NLRB*, 608 F.2d at 970.

Finally, the Board's own lack of consistency in deciding the appropriateness of health care bargaining units, such as

[16] *NLRB v. Ashkenazy Property Mgmt. Corp.*, 817 F.2d 74 (9th Cir. 1987); *Hillhouse v. Harris*, 715 F.2d 428 (8th Cir. 1983); *Beverly Enterprises v. NLRB*, 727 F.2d 591 (6th Cir. 1984); *Kitchen Fresh, Inc. v. NLRB*, 716 F.2d 351 (6th Cir. 1983); *J.P. Stevens & Co. v. NLRB*, 638 F.2d 676 (4th Cir. 1980); *Ithaca College v. NLRB*, 623 F.2d 224 (2d Cir. 1980); *Yellow Taxi Co. of Minneapolis v. NLRB*, 721 F.2d 366 (D.C. Cir. 1983).

separate maintenance units, is further cause not to apply a blanket rule to such determinations. A rule which operates to find separate units appropriate without exception when contrary results would often be reached if the same cases were decided on a case-by-case basis is clearly arbitrary and inescapably leads to further proliferation of bargaining units contrary to the Congressional admonition.

D. Proliferation Of Bargaining Units Leads To The Types of Problems Congress Feared When It Passed The 1974 Health Care Amendments.

Congress' concern about proliferation of bargaining units in hospitals was based upon a fear that proliferation would lead to numerous work stoppages, jurisdictional disputes, and wage and benefit whipsawing and leapfrogging, which, in turn, would add to the already skyrocketing costs of medical care. *See supra* pp. 5-6. The Board, in NPR II, examined the "evidence" presented in connection with its rule-making procedure and concluded that there was "little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation." 53 Fed. Reg. at 33908. As the AHA pointed out, however, "the Board's 'finding' ignores the fact that there has *not* been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach."[17] Brief for American Hospital Association, Petition for A Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 22; *American Hospital Association v. NLRB*, No. 90-97 (1990). The Seventh Circuit's sanctioning of the NLRB's clear disagreement with Congress and the court's over the effects of unit proliferation is erroneous.

[17] By the Board's own admission, only about 10% of organized hospitals negotiate three or more contracts. 53 Fed.Reg at 33908. For the Board to conclude on the basis of that record that eight units are appropriate and that such proliferation will not lead to the problems feared by Congress is, as the AHA notes, "sheer speculation." Brief for American Hospital Association, Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 22; *American Hospital Association v. NLRB*, No. 90-97 (1990).

McKeesport is an example of a hospital that has experienced negotiating and administering contracts with multiple units. Although the three bargaining units at McKeesport are several fewer than the eight permitted by the Final Rule, McKeesport's experience in dealing with as few as 3 units is indicative of the problems hospitals will face when multiple units are certified by the NLRB. McKeesport's labor history graphically illustrates the future of hospital bargaining if the Final Rule is permitted to stand.

Contrary to the NLRB's "finding" in NPR II,[18] McKeesport's experience has been that multiple units have resulted in multiple work stoppages and threats of work stoppages, wage and benefit whipsawing and leapfrogging, multiple contract negotiations, labor arbitrations and other matters which cause significant disruptions to patient care and contribute to escalating health care costs. In short, McKeesport's recent history proves that the concerns expressed by Congress as it passed the 1974 Health Care Amendments remain valid, and in McKeesport's case, have come to fruition.

As mentioned above, McKeesport has three units of represented employees. It has the potential for five, or even six, additional units under the NLRB Final Rule. Contracts for all three of McKeesport's units were due to expire in the first half of 1988. In December 1987, Teamsters Local 205, which already represented the Hospital's service employees, petitioned the NLRB for an election in a unit of technical and clerical employees. An election was scheduled for February 19, 1988. SEIU Local 585 and Office and Professional Employees International Union, Local 457, AFL-CIO, also secured places on the ballot and became involved in the organizing campaign.

During the election campaign, in what is widely-believed to have been a show of strength intended to influence the

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[18] The Board does not discuss the effects of proliferation in its Final Rule other than to note that it had thoroughly considered such arguments in NPR I and NPR II and that no further consideration or response was required. 54 Fed. Reg. at 16337.

election and "whipsaw" the Hospital, 250 of the employees represented by the Teamsters walked off their jobs, without giving the Hospital notice as required by Section 8(g) of the Act, 29 U.S.C. § 158(g).[19] In fact, the teamster walkout came without any warning. It was also in derogation of a no-strike clause in the labor agreement. When the employees refused to return to work, McKeesport had no choice but to replace the employees participating in the illegal walkout in order to continue to provide care to its patients.

As could be expected, the illegal walkout and McKeesport's reaction triggered a flurry of legal actions. McKeesport filed unfair labor practice charges against the Union for violation of Sections 8(g) and 8(b)(1)(A) of the Act, 29 U.S.C. §§ 158(g), 158(b)(1)(A), and brought suit in federal court seeking, *inter alia*, damages under Section 301 of the Labor-Management Relations Act, 29 U.S.C. § 185. The Teamsters, for its part, also filed unfair labor practice charges and grieved the Hospital's decisions to terminate and replace its members. After the parties disputed the

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[19] In NPR II, the Board suggested that hospitals seek common expiration dates to solve problems caused by recurring near-strikes including multiple § 8(g) strike notices. 53 Fed.Reg. at 33909. Not only is such a suggestion incredibly naive, ignoring as it does the realities of hospital bargaining, but McKeesport's experience has shown that contemporaneous expiration dates actually exacerbate problems rather than solve them. Unions have recognized the bargaining leverage separate expiration dates provide. It is thus highly unlikely that a self-respecting union would simply give away this leverage in order to serve the public interest of forestalling problems caused by recurring near strikes. Even assuming that a hospital could negotiate common expiration dates, that would not assure that all of its unions would give simultaneous § 8(g) strike notices. The timing of such notices is entirely within the discretion of the union. If a union was inclined to work beyond the contract expiration date, it could simply delay giving its § 8(g) notice and unions acting in concert could "whipsaw" the hospital to death through sequential and multiple notices of an impending strike. The hospital would then be forced either to allow the employees to work under the expired contract or to lock them out and cause a disruption of its operations. Following the Board's suggested approach would virtually require a hospital to close down and lay off non-striking employees every time the multiple contracts were set to expire. Planning to operate a hospital under the simultaneous threat of multiple work stoppages would be virtually impossible.

arbitrability of the grievances because of the effect of Section 8(d) of the Act on the employees' status, 29 U.S.C. § 158(d), the Union brought suit in federal court to compel arbitration.

Contemporaneous with the illegal Teamsters strike, negotiations had begun with SEIU Local 585 for the nurses' unit. Local 585 was involved in the NLRB election campaign for the technical/clerical unit and obviously sought to use the negotiations to bolster its chances of victory in the election.[20] In this charged environment, the nurses came to the bargaining table disgruntled about perceived wage inequities and fringe benefit disparities in the expiring contract. At the bargaining table, SEIU Local 585 sought to make up for these perceived disparities and demanded substantial increases. As negotiations continued, Local 585 informed the hospital that it would strike on March 22, 1988.

In response to Local 585's Section 8(g) 10-day strike notice, McKeesport had no choice but to take the steps that any prudent hospital *must* take to protect the well being of patients when faced with a Section 8(g) strike notice. Thus, McKeesport began to curtail admissions, canceled elective surgeries and began preparations to transfer patients to other institutions. McKeesport also began to implement plans to lay-off other employees and to consolidate operations by closing several hospital units. Fortunately for McKeesport's patients and the community, the Hospital and Local 585 reached agreement on the eve of contract expiration, thereby averting a strike.[21]

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[20] The first election in the proposed technical/clerical unit was held on February 19, 1988. No union received a majority vote. The NLRB then scheduled a run-off between the Teamsters and "No Union" on March 17, 1988. At the March 17 run-off election, the employees voted to remain unrepresented.

[21] Contrary to the NLRB's assumptions, Section 8(g) has been somewhat of a mixed blessing. While it undoubtedly protects hospitals and their patients when a strike does occur, it places a burden upon hospitals and their patient community in the many more cases where the contract is settled short of a strike, almost always at the eleventh hour after the 8(g) notice and the hospital's prudent preparatory response. Most unions tend to give section 8(g) notices 10 days prior to contract expiration as a matter of course. The hospital, its physicians, its

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The agreement with Local 585 provided for significant economic increases. Because of Local 585's leverage, and in the context of the ongoing Teamster troubles, the Hospital was pressured to accede to many Union demands since a nurse's strike most assuredly would have closed the Hospital for the duration of the strike, and quite possibly could have forced permanent reductions in the Hospital's operations due to the concurrent lingering effects of the Teamsters' walkout. Patients would have to be discharged or transferred.

Shortly after narrowly averting a strike by the nurses, McKeesport was again involved in difficult contract negotiations – this time with Teamsters Local 205.[22] These negotiations were conducted in the very charged environment following the Teamsters' election defeat and the many legal and other disputes between the Teamsters and the Hospital occasioned by the illegal walkout.

Just two months later, the Hospital faced the expiration of the Operating Engineers' contract who also demanded a hefty increase, leveraging off the effects of the labor disputes with SEIU and the Teamsters. Once again, the Hospital was compelled to maintain labor peace and to recognize the Operating Engineers' leverage. After the illegal Teamsters' walkout and the near strike by the nurses, McKeesport could not risk further negative effects from another work stoppage or the attendant legal costs if it had to face a strike by its maintenance workers, who, while small in number, occupied positions critical to continued operation of the Hospital.

Before McKeesport had fully recovered from the 1988 labor problems occasioned and exacerbated by the multiple units, the Hospital was faced with a new, serious threat. The nurses' contract

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patients and their families incur significant economic, operational, emotional, professional and quality of care burdens in responding to a § 8(g) notice. Those burdens will be exacerbated as the potential for even more frequent notices is created by the existence of additional separate bargaining groups as encouraged by the Rule.

[22] The Teamster agreement expired May 1 and the negotiations actually had begun before March 22 while the Nurses' negotiations were still in progress.

with SEIU Local 585, negotiated in 1988, expired in the spring of 1990. Unlike 1988, however, the parties were unable to reach agreement in time to prevent a strike. The work stoppage lasted from March 1 until March 17, 1990. The impact on patient care and other hospital operations was dramatic. The economic consequences were substantial. Once again, the hospital had to implement its strike contingency plans even before the strike began. Admissions were curtailed, non-essential surgery was cancelled, and patients, some seriously ill, were transferred by ambulance to other institutions. The hospital had to "staff-down" because of the strike and in the process laid off hundreds of service, maintenance, technical, and clerical employees. Additional units obviously would pose a very real threat of additional strikes.

The lay-offs and subsequent recall of these employees engendered further labor disputes involving the employees represented by other labor organizations. Numerous employees grieved either their initial lay-off or circumstances relating to their recall. There were over 50 such grievances pursued to arbitration. Other side effects of the lay-offs include severely dampened employee morale and heightened tensions between the various units of Hospital employees. McKeesport expects that these and other problems resulting from the nurses' strike may continue well into the future.

McKeesport's 1988 labor problems from its multiple units and the experience with the 1990 nurses' strike resoundingly affirm the validity of Congress' concerns upon passage of the 1974 Health Care Amendments. With the Teamsters, Operating Engineers and SEIU contracts all expiring within the same general time period, each union used the other unions' threats, demands and bargaining gains as leverage to gain agreement for its own bargaining proposals. Further, we submit, both the Teamsters and Local 585 undoubtedly used the negotiations to attempt to influence to NLRB election in the technical/clerical unit.

Finally, the nurses' strike caused disruptions not only in patient care but in the Hospital's relationship with its other Unions. The end result of these activities by multiple units was precisely the kind of whipsawing, leapfrogging and work stoppages that Congress feared when it passed the Health

Care Amendments. Despite these experiences, which undoubtedly are or will be repeated at other hospitals with multiple units, the NLRB found little "evidence" that Congress' concerns were valid. That conclusion is flawed.

The time, effort and expense associated with negotiating and administering contracts with multiple units has dramatically increased non-patient care related operating costs at McKeesport.[23] Such costs will certainly increase exponentially if the NLRB's eight unit Final Rule is permitted to stand, all at a time when Congress and the public have become increasingly alarmed about rising health care costs. In this regard, a recent study predicts that the per capita cost of health care in this country will increase 127% from 1990 to the year 2000. The same report found that increases in total health care spending exceeded increases in per capita spending between 1980 and 1990 by more than 24%.[24] The government, which already bears a substantial burden of health care costs, will be faced with sharing more of the burden, or reducing programs, as evidenced by recent changes in the hospital reimbursement system.[25]

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[23] For example, in its Final Rule, the Board itself cites evidence that negotiation of a single collective bargaining agreement can cost between $15-40,000 in legal fees alone. 54 Fed.Reg. at 16339. Other costs for negotiations which are also very significant include staff time devoted to actual bargaining, costs associated with surveying local wage rates in other institutions, drafting and costing contract proposals and counter-proposals, studying the potential impact of proposals on operations and clerical duties relating to the preparation of draft proposals, bargaining notes and final proposals. Unless some economies could be achieved, these costs potentially would be multiplied *eight times* if the Board's Final Rule is permitted to stand. Further, the NLRB's Rule is totally unmindful of the fact that the burden of these costs ultimately falls upon the patient-consumers of health care services and, to a large extent, upon the United States government which foots the bill for a significant percentage of all health care expenses.

[24] *Families USA Calls for Bold Action to Stem Health Care Cost Explosion,* Daily Lab.Rep. (BNA) No. 212 at A-10, A-11 (Nov. 1, 1990).

[25] In 1982, Congress enacted the Prospective Payment System, which revised the Medicare payment system. Under this system, Medicare patients' diagnosis, rather than the cost of treating the patient, dictates the amount of reimbursement received by the hospital. Diagnostic related groups ("DRGs") become an integral part of the system. DRGs establish the amount of payment

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Additionally, many hospital costs and increases are non-reimbursable. Government payments to hospitals under Medicare and Medicaid – which together account for about one-half of all hospital revenues and, in the case of McKeesport, account for approximately 68% – are falling far behind the actual costs of delivering care.

These changes have an immediate impact on the magnitude of declining revenues. Today, many hospitals are facing critical financial situations and it has been projected that the number of acute care hospitals in this country will decline drastically as a result of involuntary closings which will deprive communities of much needed health care.

Concurrently, as non-hospital-based health care delivery systems have been developed, admissions have declined leaving hospitals with fewer, but more acutely ill patients and leaving hospitals even more vulnerable to DRG reimbursement. Shortages in a variety of health care professions, such as nursing, have caused a drastic increase in the labor costs associated with those professions.

Even as hospitals search for solutions to these changes, the problems are intensified by new challenges. Hospitals such as McKeesport are not only faced with providing care to an increasingly acutely ill and aging patient population, but also with providing increasingly larger amounts of unreimbursed care to uninsured patients and to patients with AIDS and drug related conditions.

As is apparent from the foregoing, Congress' concern of increased costs resulting from unit fragmentation applies with even more urgency in today's economy. Thus, it is imperative that the NLRB pay heed to Congress' admonition and recognize this important public interest in preventing unit proliferation.

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associated with any particular illness or condition. DRGs are based upon the costs typically involved in treating a specific illness or condition. Unfortunately for the hospital, the amount of DRG reimbursement was usually unaffected by patients whose treatment does not fall within the norm in terms of length of stay, procedures performed, etc. Thus, the amount of reimbursement received by the hospital often does not correlate to the cost incurred by the hospital.

As stated above, at McKeesport, for example, about 68% of all admissions are paid for by Medicare or the Pennsylvania Medical Assistance Program. Other Southwestern Pennsylvania hospitals compare at approximately 67%. *Hospital Costs Rise 17.4%*, Pittsburgh Post-Gazette, Aug. 14, 1990 at 6, col. 2. As a result, public funds budgeted for these critical programs, which would otherwise be used in direct patient care activities, will, by necessity, be used to cover increased operating costs resulting from strikes, multiple union organizing campaigns and negotiations, whipsawing and leapfrogging.[26] The public interest is not served by diverting public funds from critical health care programs to cover non-patient care activities, thereby decreasing the quality and amount of health care available to people who rely on such programs.

The NLRB in its rulemaking essentially ignored the public interest in affordable health care as a factor militating against unit proliferation. In its Final Rule, referring to the "implicit policy" of the 1974 amendments, the Board concluded:

> The statutory amendments enacted by Congress in 1974 represented an *implicit* policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the cost.

54 Fed.Reg. at 16,339 (emphasis added). This "implicit" policy should not be given paramount importance over Congress' *expressed* concern to control health care costs by avoiding the proliferation of bargaining units, particularly when it has not been shown by the NLRB that fragmentization

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[26] Several labor organizations have made it known publicly that they have planned massive organizing efforts at hospitals if the Final Rule is upheld. National Union of Hospital and Health Care Employees President Henry Nicholas recently announced that the NUHHCE will triple its monthly union dues to finance a massive organizing effort. *Health Care Employees Union Plans Massive Organizing Campaign*, Daily Lab.Rep. (BNA) No. 213 at A-18 (Nov. 2, 1990). The American Nurses Association and other unions have made similar claims. *ANA Facing Challenges From Rival Nurse Unions*, Daily Lab.Rep. (BNA) No. 120 at A-5 (June 21, 1990). Hospitals will be required to expend commensurate resources to respond to the legal proceedings engendered by these increased efforts.

of units is absolutely necessary to afford employees the benefits of collective bargaining. The Board simply brushed aside Congress' *express* policy decision that unit proliferation should be prevented because of its negative impact on health care costs. By upholding the Board's Final Rule, the Seventh Circuit has sanctioned the Board's clear departure from Congress' intent.

The experience of McKeesport in dealing with only three units, instead of the eight units set forth in the Final Rule, is compelling evidence that the proliferation of units in hospitals not only causes disruptions to patient care by work stoppages, multiple contract negotiations and whipsawing and leapfrogging, but also increases medical costs and threatens the financial stability of hospitals which encounter these tactics effectively utilized by unions.

CONCLUSION

For the foregoing reasons, St. Margaret Memorial Hospital, McKeesport Hospital and Hospital Association of Pennsylvania, *amici curiae*, respectfully request that the Court reverse the Court of Appeals' decision.

Respectfully submitted,

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